

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11847

CERTIFICATE OF DEATH

11831

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i> | | c. LENGTH OF STAY IN 1b <i>2 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EASTON MEMORIAL Hosp</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>CARROLL</i> Middle <i>L E E</i> Last <i>Adams</i> | | 4. DATE OF DEATH Month <i>Oct</i> Day <i>18</i> Year <i>1959</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>SEPT 22 1884</i> |
| 9. AGE (In years last birthday) <i>75</i> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER - RET.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | |
| 13. FATHER'S NAME <i>Edwards Adams</i> | | 14. MOTHER'S MAIDEN NAME <i>Nellie Moore</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | |
| 17. INFORMANT <i>HOSPITAL RECORDS</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Deviated septum</i> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10/21/59</i> to <i>10/21/59</i> , that I last saw the deceased alive on <i>10/21/59</i> and that death occurred at <i>9:25 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> | | ADDRESS (Street, city or town, state) <i>2195 West 11th St. Baltimore, Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i> | | DATE SIGNED <i>Oct 21 1959</i> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>10/21/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i> | 22d. LOCATION (City, town, or county) (State) <i>EASTON, MD.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hampton Connel</i> | | ADDRESS <i>EASTON</i> | |
| 24a. REC'D BY REGISTRAR <i>Oct 29 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>William E. Jones</i> | |

CERTIFICATE OF DEATH

1921

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11848

CERTIFICATE OF DEATH

11832

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FEDERALSBURG</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG Md. - Rural</u> | | | |
| c. LENGTH OF STAY IN 1b <u>3 days</u> | | | | d. STREET ADDRESS <u>R.F.U. #1 - Allen's Corner</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Williams</u> Last <u>Andrews</u> | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2</u> <u>1917</u> | |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseworker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland, Caroline Co.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Raymond H. Williams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Finnie Cannon</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT Address <u>Finnie C. Williams, Federalsburg, Md., RFD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive encephalopathy</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO <u> </u> (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u> </u> 19 <u> </u> to <u> </u> 19 <u> </u> , that I last saw the deceased alive on <u> </u> 19 <u> </u> and that death occurred at <u>10:40 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> | | | | ADDRESS (Street, city or town, state) <u>2195 West 11th St. SE</u> DATE SIGNED <u>Oct 5 1959</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> | | | | Canton, Md., Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>October 6, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Seaford Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Seaford, Delaware</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frempton and Son</u> ADDRESS <u>Federalsburg, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 5 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

11866

CERTIFICATE OF DEATH

11834

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Shrewood</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Shrewood</u> | |
| c. LENGTH OF STAY IN 1b <u>26 yrs</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>Cright</u> Middle <u>Bowman</u> Last | | 4. DATE OF DEATH <u>Oct.</u> Month <u>10</u> Day <u>1959</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 10, 1880</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Richard Cright</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Kohl</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Fredrick K. Bowman</u> Address <u>Shrewood Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalised.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years -</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>54</u> , to <u>10-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-10</u> , 19 <u>59</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>210 E. Dover - Easton Md.</u> DATE SIGNED <u>10/11/59</u> | | | |
| ACTUAL SIGNATURE <u>William L. Winters</u> M.D. | | PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS M.D.</u> <u>210 E. DOVER EASTON MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 17, 59</u> | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY <u>First Friends</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert [unclear]</u> ADDRESS <u>Easton Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE OCT 13 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur [unclear]</u> |

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CERTIFICATE OF DEATH

Reg. Dist. No.

11849

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|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville Md. 17X-2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>M</u> Last <u>Butler</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 10, 1895</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Md. Queen Anne's Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter Sparks</u> | | 14. MOTHER'S MAIDEN NAME <u>Minnie M.C. Lynett</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-28-4905</u> | |
| 17. INFORMANT <u>Henry S. Smith Sr. Queen Anne's Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemo-hydrathorax</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma of breast</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D. | | ADDRESS (Street, city or town, state) <u>219 S. Washington St. 20059</u> | |
| PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> | | DATE SIGNED <u>Easton 16, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 22b. DATE THEREOF <u>Oct 5-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u> | 22d. LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. Centerville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 7 1959</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hines</u> |

TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 11850 11836 Reg. Dist. No. 1 VS A15 (4) 15M 10/57

Item 1 Film 6251 11-13-59 et

CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. LENGTH OF STAY IN 1b 10 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Earle Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Maude Middle A Last Cameron | | 4. DATE OF DEATH Month October Day 30 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 4, 1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Ash | | 14. MOTHER'S MAIDEN NAME Mary Peightel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Philip J. Hopkins | | Address Easton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465x Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (?) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 1954 to 30 Oct 1959 , that I last saw the deceased alive on 29 Oct 1959 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Thorston Harrison M.D. Carlton S. Kraus DATE SIGNED 30 Oct 59 PHYSICIAN'S NAME (Type) THORSTON HARRISON 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Nov. 2, 1959 22c. NAME OF CEMETERY OR CREMATORY Bellwood Cemetery 22d. LOCATION (City, town, or county) (State) Bellwood Pa. 23. FUNERAL DIRECTOR'S SIGNATURE J. Harvey Williams ADDRESS Federalsburg, Md. 24a. REC'D BY REGISTRAR DATE NOV 6 '59 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus | | | |

MASSACHUSETTS

DEPARTMENT OF HEALTH

1920

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11867
CERTIFICATE OF DEATH

11837

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel | | c. LENGTH OF STAY IN 1b 8 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle WEED Last CODINGTON | | 4. DATE OF DEATH Month Oct. Day 31 Year 1959 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 2, 1879 |
| 9. AGE (In years last birthday) 80 yn. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY farm | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Harry S. Codington | | 14. MOTHER'S MAIDEN NAME Emma Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-16-8354 | |
| 17. INFORMANT Mrs. Harry Codington | | Address McDaniel, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral (arterial) Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO 5 years (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Hyperglycemia | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 2, 1959 , to Nov. 4, 1959 , that I last saw the deceased alive on Nov. 2, 1959 , and that death occurred at 12:00 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dr. R. Lane Wroth | | M.D. St. Michaels, Md. DATE SIGNED 11-1-59 | |
| PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth | | St. Michaels, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 2, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery | | 22d. LOCATION (City, town, or county) (State) Oxford, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son | | ADDRESS Easton, Md. | |
| 24a. REC'D BY REGISTRAR DATE NOV 4 '59 | | 24b. REGISTRAR'S SIGNATURE Carlton S. Thomas | |



11851

CERTIFICATE OF DEATH

11838

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL | | | | d. STREET ADDRESS 131 FLOYD LANE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY DICKERSON | | | | 4. DATE OF DEATH Month Day Year October 5 1959 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 15, 1888 | |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME ALEX DICKERSON | | | | 14. MOTHER'S MAIDEN NAME MATILDA THOMAS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT GRACE DICKERSON-wife-EASTON, MD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | |
| 4 DUE TO ARTERIOSCLEROTIC HEART DISEASE | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 mos | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from JULY 1959 to OCT. 5 1959 , that I last saw the deceased alive on OCT. 5 1959 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Donald A. Bartley M.D. | | | | ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON, MD. | | | |
| DATE SIGNED 10-5-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) DONALD F. BARTLEY, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9-59 | | 22c. NAME OF CEMETERY OR CREMATORY "Family Cemetery" | | 22d. LOCATION (City, town, or county) (State) Trappe, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James D. Phillips, Easton, Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE OCT 12 '59 | |
| 24b. REGISTRAR'S SIGNATURE William E. Kneass | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11839

11852

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>6 1/2</u> hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTON Memorial Hosp.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u> d. STREET ADDRESS <u>Near Lynson</u> e. IS RES. D.T. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Leon</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1959</u> | | 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>About 1919</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) <u>40</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm and Factory</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> | | | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | | 17. INFORMANT <u>Maryland State Police, Easton, Maryland</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>781x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound R. thigh</u> (c) <u> </u> DUE TO (d) <u> </u> DUE TO (e) <u> </u> DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot gun wound</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> o. m. <u>10/25</u> 19 <u>59</u> | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u> | | 20f. (City or town) <u>Lynson</u> | | (County) <u>Dor.</u> (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> | | | | EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Oct. 28, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rhodesdale Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Near Rhodesdale, Maryland</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u> | | | | | | 24a. REC'D BY REGISTRAR <u>Nov 3 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12/1/59

mnb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

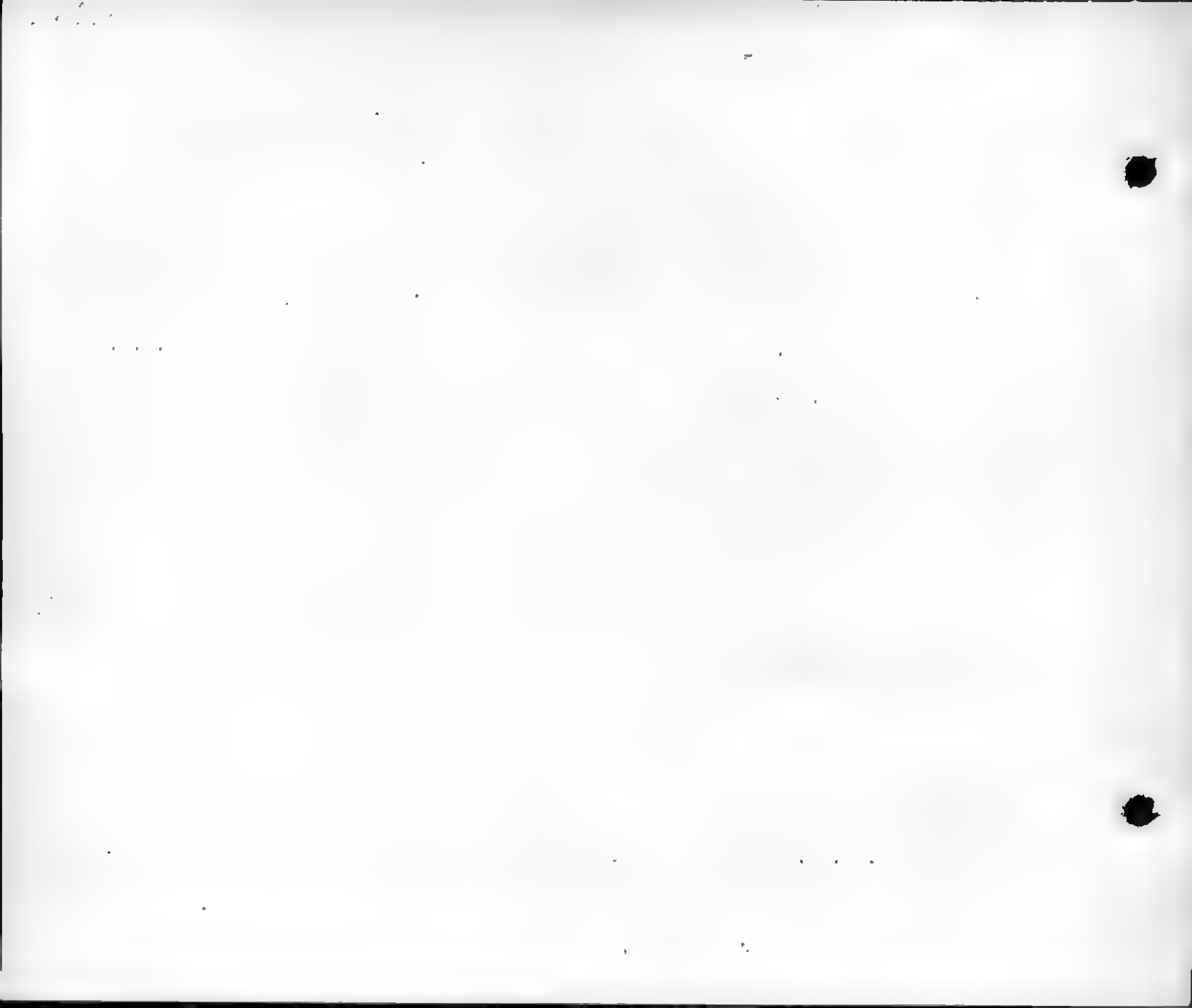
CERTIFICATE OF DEATH

Reg. Dist. No.

14160

11853

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN lb 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman d. STREET ADDRESS 11 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First George Middle Dewey Last Faulkner | | 4. DATE OF DEATH Month October Day 10 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 27, 1898 |
| 9. AGE (In years last birthday) 61 | | 10. IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min. 59 | 11. IF UNDER 24 HRS Months 10 Days 10 Hours 19 Min. 59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery Opr. | | 10b. KIND OF BUSINESS OR INDUSTRY Food Pro. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert N. Faulkner | | 14. MOTHER'S MAIDEN NAME Nora Taylor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastric hemorrhage. DUE TO (b) Oesophageal varicies. DUE TO (c) Cirrhosis of the liver. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at 3:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE E. C. H. Schmidt M.D. | | 12/1/59 | |
| PHYSICIAN'S NAME (Type) E. C. H. Schmidt, 219 S. Washington Street, Easton, Md. | | 12/1/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/13/59 | 22c. NAME OF CEMETERY OR CREMATORY Tilgh. Meth. | 22d. LOCATION (City, town, or county) (State) Tilghman, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll, Easton, Md. | | 24a. REC'D BY REGISTRAR DEC 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE | | | |



11854
CERTIFICATE OF DEATH

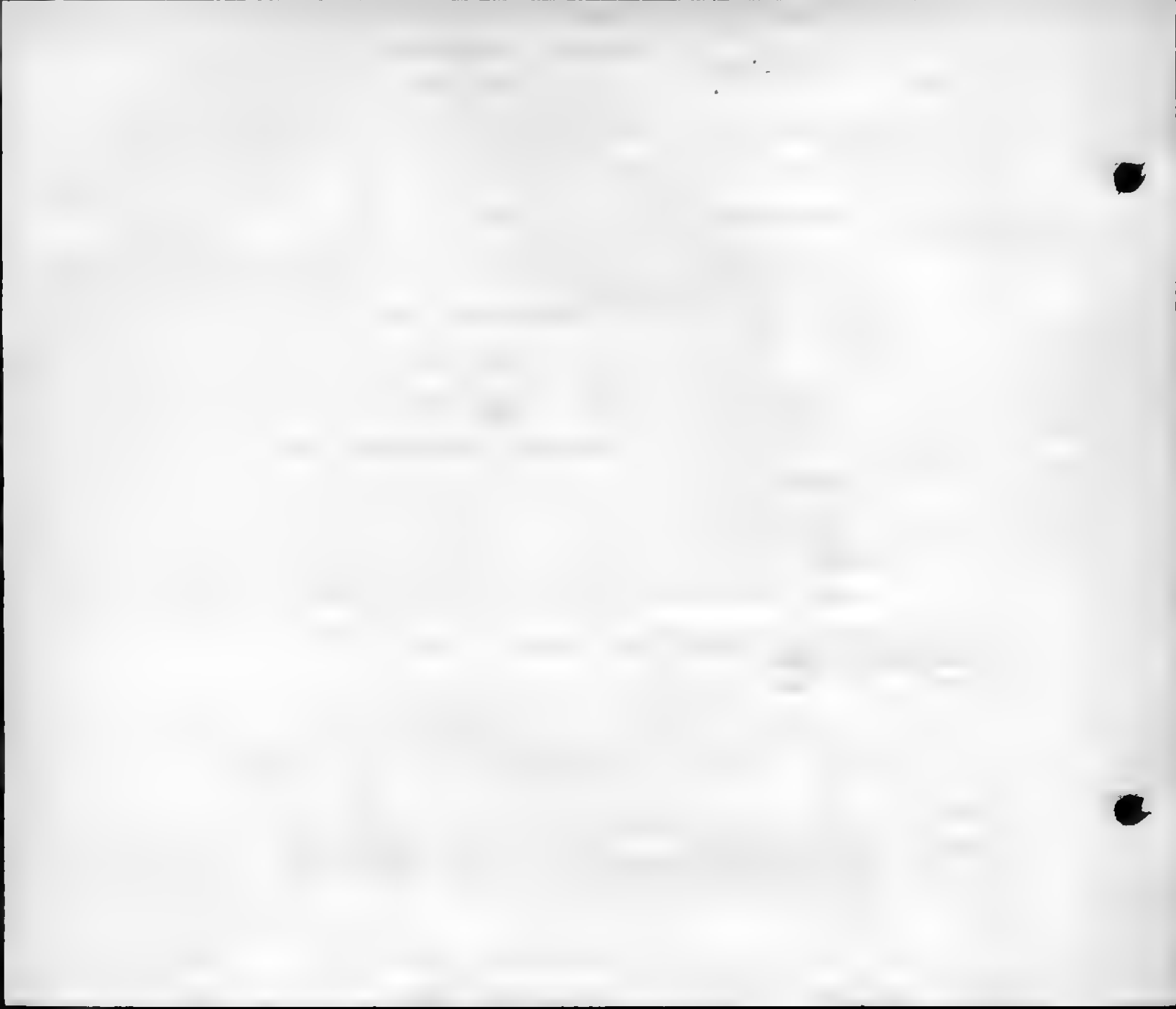
Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>211 N Fourth ST</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Friend (A)</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1959</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 12, 1959</u> |
| 9. AGE (In years last birthday) yrs. <u>3</u> | | IF UNDER 1 YEAR: IF UNDER 24 HRS: Months <u>3</u> Days <u>40</u> Hours <u>40</u> Min <u>40</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Donald Charles Friend</u> | | 14. MOTHER'S MAIDEN NAME <u>Joyce Taylor</u> | |
| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>Mother</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>59</u> to <u>10/12</u> , 19 <u>59</u> that I last saw the deceased alive on <u>10/12/59</u> , 19____, and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>11/7/59</u> | |
| PHYSICIAN'S NAME (Type) <u>P F Cox</u> | | <u>EASTON MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct. 13, 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Sprucegrove</u> | 22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Denton</u> | | 24a. REC'D BY REGISTRAR DATE <u>NOV 16 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

11855

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | | | d. STREET ADDRESS 211 N. Fourth ST | | | |
| 3. NAME OF DECEASED (Type or print) Baby Boy Friend (B) | | | | 4. DATE OF DEATH October 12 1959 | | | |
| 5. SEX M | | 6. COLOR OR RACE C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 12, 1959 | |
| 9. AGE (In years last birthday) 59 | | IF UNDER 1 YEAR Months Days Hours Min | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13. FATHER'S NAME Donald Charles Friend | | | | 14. MOTHER'S MAIDEN NAME Joyce Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Mother Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776x DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 59 min |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/12 19 59 , to 10/12 19 59 , that I last saw the deceased alive on 10/12/59 , and that death occurred at 7 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md DATE SIGNED 11/7/59 | | | | | | | |
| ACTUAL SIGNATURE P. F. Cox M.D. | | | | PHYSICIAN'S NAME (Type) Easton Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Oct 13, 1959 | | Spring Grove | | Denton Cal. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Virgie Moore & Son ADDRESS Denton | | | | 24a. REC'D BY REGISTRAR DATE NOV 16 59 | | 24b. REGISTRAR'S SIGNATURE Arthur & Hanna | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11840

11868

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak | | c. LENGTH OF STAY in 1b life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thornton Road | | d. STREET ADDRESS Thornton Road | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH PETERS HALL | | 4. DATE OF DEATH Month October Day 25 Year 19 59 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 15, 1888 |
| 9. AGE (In years last birthday) 71 ym. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Charles W. Peters | | 14. MOTHER'S MAIDEN NAME Sally Kelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 21Q-07-9627 | |
| 17. INFORMANT Mrs. Dade Davis | | Address Woodbine, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Tuberculosis - Healed | | INTERVAL BETWEEN ONSET AND DEATH 4 mon | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1957 to 25 October 1959 that I last saw the deceased alive on 24 October 1959 and that death occurred at 2:50 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE K. Lane Wroth M.D. | | ADDRESS (Street, city or town, state) St. Michaels, Md. | |
| DATE SIGNED 10-26-59 | | | |
| PHYSICIAN'S NAME (Type) Dr. Lane Wroth | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 27, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son | | ADDRESS Easton, Maryland | |
| 24a. REC'D BY REGISTRAR DATE OCT 30 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Thomas | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11841

11856

Item 9 Film 6252 12-1-59 et

Reg. Dist. No.

| | | | | | |
|---|--|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b 23 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Easton Memorial Hospital | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY TALBOT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON d. STREET ADDRESS "Radcliffe Manor" | | e. IS RESIDENCE OF A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Helen First Harding Middle Last 4. DATE OF DEATH 10 20 1959 Month Day Year | | 5. SEX Fe 6. COLOR OR RACE Blk 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 15, 1910 9. AGE (In years last birthday) 49 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME Artie Wilmer | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Clarence Harding, husband - same Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BSW head 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 23 hrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 10-19 1959 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | |
| 20f. (City or town) W. Easton | | 20g. (County) Talbot | | 20h. (State) MD | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Louis M. McIntyre | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10-21-59 | |
| EXAMINER'S NAME (Type) INELTY | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 10/24/59 | | 22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery | |
| 22d. LOCATION (City, town, or county) Easton | | 22e. (State) MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell | | ADDRESS Easton MD | | 24a. REC'D BY REGISTRAR NOV 2 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE C. J. Howard | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 7 days after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11857

CERTIFICATE OF DEATH

11842

Reg. Dist. No.

| | | | | | | | |
|--|-----------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Telbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>High Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Clive Virginia Holmes</u> | | | | 4. DATE OF DEATH Month Day Year <u>October 2 19 59</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 5, 1921</u> | 9. AGE (In years last birthday) <u>38 yrs.</u> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Denton, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Ollie</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cora Flamer</u> | | | |
| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT Address <u>Mrs. Addison Stanford (Mother), Denton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholic encephalopathy</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Alcoholic peripheral neuritis</u> DUE TO (c) <u>Laennec's cirrhosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholic peripheral neuritis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>9-29</u> , 19 <u>59</u> , to <u>10-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>59</u> , and that death occurred at <u>4:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Denton, Maryland</u> DATE SIGNED <u>10-3-59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Robert W. Trever</u> | | | | M.D. <u>202 Dover St.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u> | | | | <u>Easton, Md.</u> | | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 5, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Denton, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. J. Trappington, Don Federalburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 8 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Chas. A. Howard</u> | |



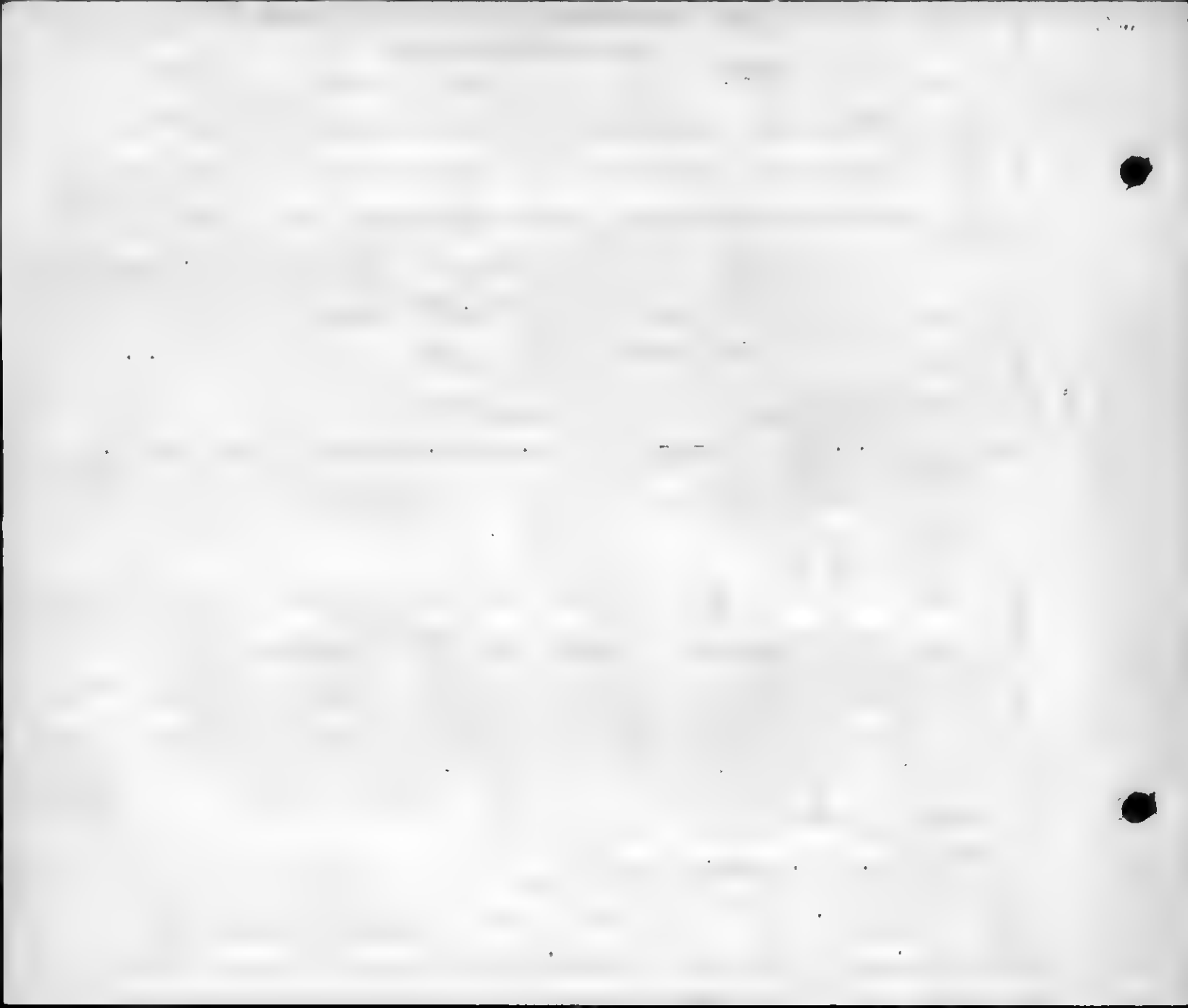
CERTIFICATE OF DEATH

11869

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Royal Oak | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × rural Royal Oak | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edge Plain Farm | | | | /d. STREET ADDRESS Edge Plain Farm | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle NELSON Last MACGOWAN | | | | 4. DATE OF DEATH Month October Day 4 Year 19 59 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 23, 1897 | | 9. AGE (In years last birthday) 62 yrs | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President American Export Lines | | | | 10b. KIND OF BUSINESS OR INDUSTRY Canada | | 11. BIRTHPLACE (State or foreign country) U.S. | |
| 13. FATHER'S NAME John MacGowan | | | | 14. MOTHER'S MAIDEN NAME Clara Settle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | (If yes, give war or dates of service) W.W.I | | 16. SOCIAL SECURITY NO. 106-18-1340 | | 17. INFORMANT Mrs. John N. MacGowan Address Royal Oak, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1-2 hr. 2-3 yr. 2-3 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Easton, Md. | |
| 20f. (City or town) Easton, Maryland | | | | 20g. (County) Princess Anne | | | |
| 20h. (State) Md. | | | | | | | |
| 21. I certify that I attended the deceased from 2-21 , 19 58 to 10-4 , 19 59 that I last saw the deceased alive on 10-2 , 19 59 , and that death occurred at 1-PM from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William L. Winters M.D. | | | | ADDRESS (Street, city or town, state) Easton, Md. | | | |
| DATE SIGNED 10/6/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Wm L. Winters | | | | Easton, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 7, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son | | | | ADDRESS Easton, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 8 1959 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur B. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11858

CERTIFICATE OF DEATH

Reg. Dist. No.

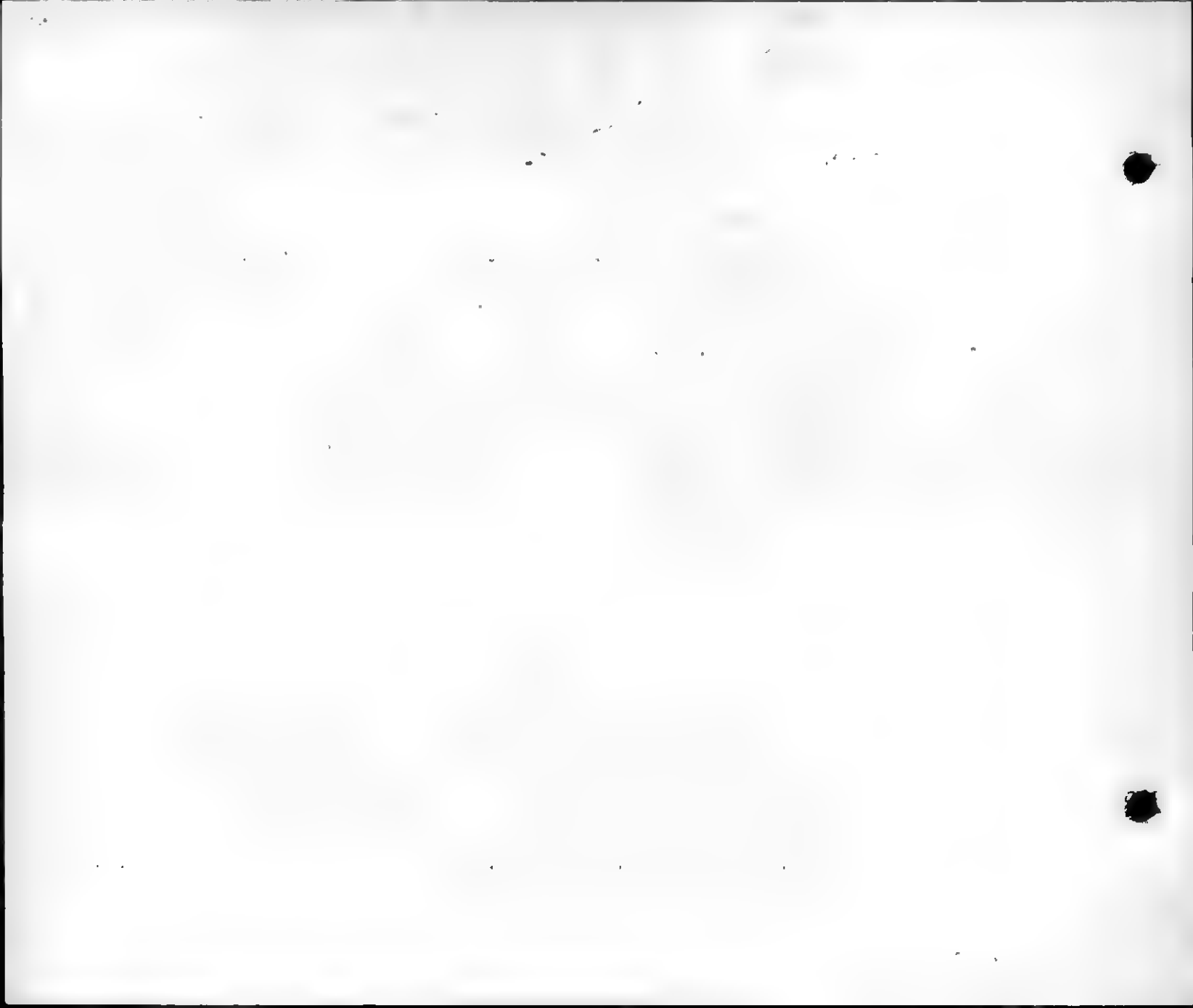
| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Fred Middle R. Last McNeal | | | | 4. DATE OF DEATH Month October Day 9 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 7, 1889 | |
| 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS Months Days Hours Min | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Md.S.R. Commission | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Rufus McNeal | | | | 14. MOTHER'S MAIDEN NAME Anne McCracklin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. unknown | | INFORMANT Wife, Weston, Md. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ascending Cholangitis 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Cholelithiasis DUE TO (c) Septicemia | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days. Yrs. 10 days. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 10-1- 19 59 to 10-9- 19 59 that I last saw the deceased alive on 10-9- 19 59 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Donald F. Bartley M.D. | | | | ADDRESS (Street, city or town, state) 9 N. HANSON ST. DATE SIGNED 12/1/59 | | | |
| PHYSICIAN'S NAME (Type) Donald F. Bartley, 9 N. Hanson St., Easton, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY Spring Will Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll, Easton, Maryland | | | | 24a. REC'D BY REGISTRAR DATE DEC 7 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12/1/59

MNB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

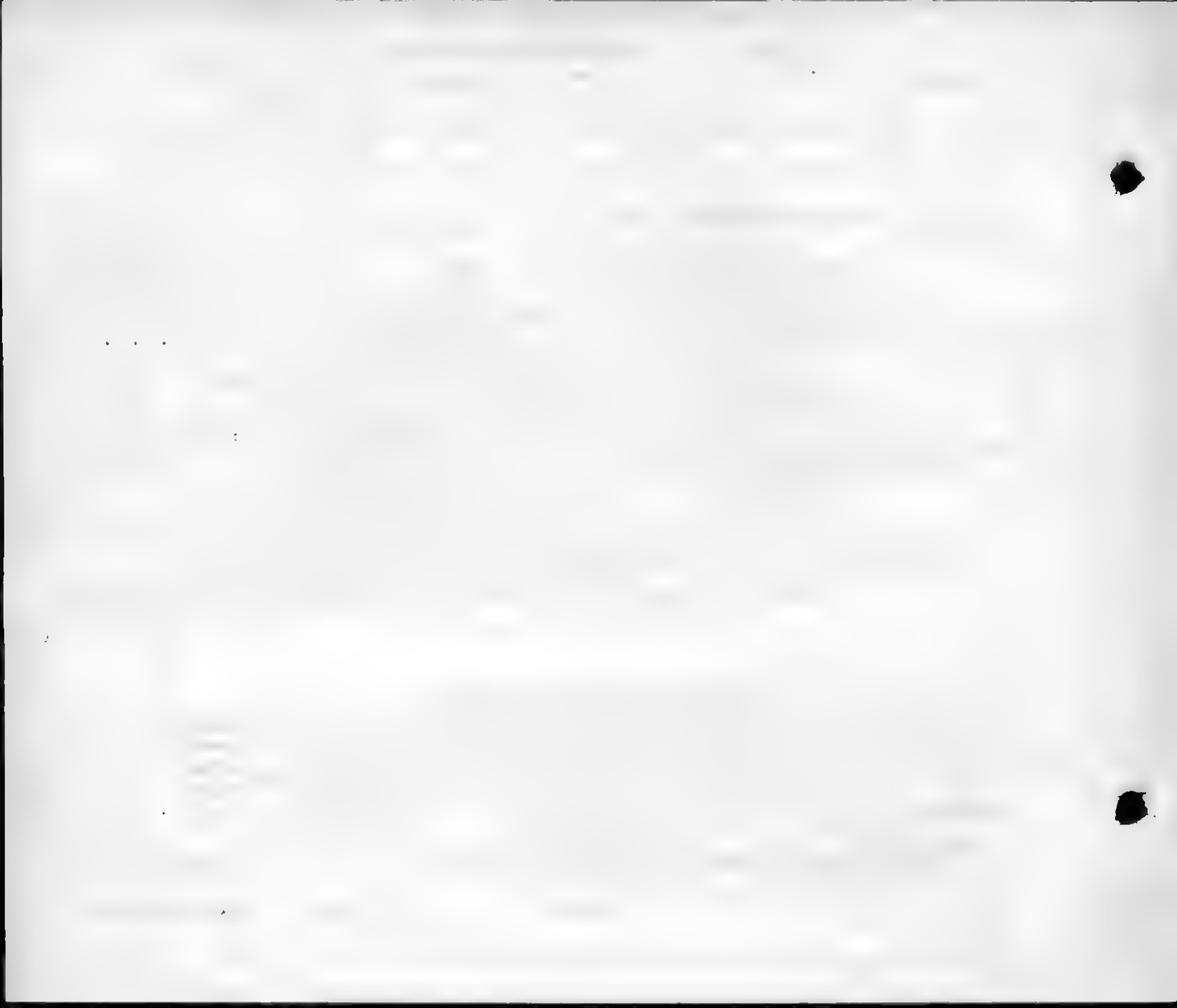
11844

11859

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marydel</u> | |
| c. LENGTH OF STAY IN 1b <u>2 days</u> | | d. STREET ADDRESS <u>None</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Steven</u> <u>Rodimak</u> | | 4. DATE OF DEATH Month Day Year <u>October</u> <u>13</u> <u>1959</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 10, 1924</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>No Record</u> | | 14. MOTHER'S MAIDEN NAME <u>No Record</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>113-03-0403A</u> | |
| 17. INFORMANT Address <u>Anna Radimak Marydel, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>for 40 years</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12 Oct</u> , 19 <u>59</u> , to <u>13 Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 Oct</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. | | ADDRESS (Street, city or town, state) <u>Caroline Maryland</u> DATE SIGNED <u>12 Oct 59</u> | |
| PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-17-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u> | 22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulinis</u> ADDRESS <u>Greensboro, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 19 59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Charles L. Frank</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

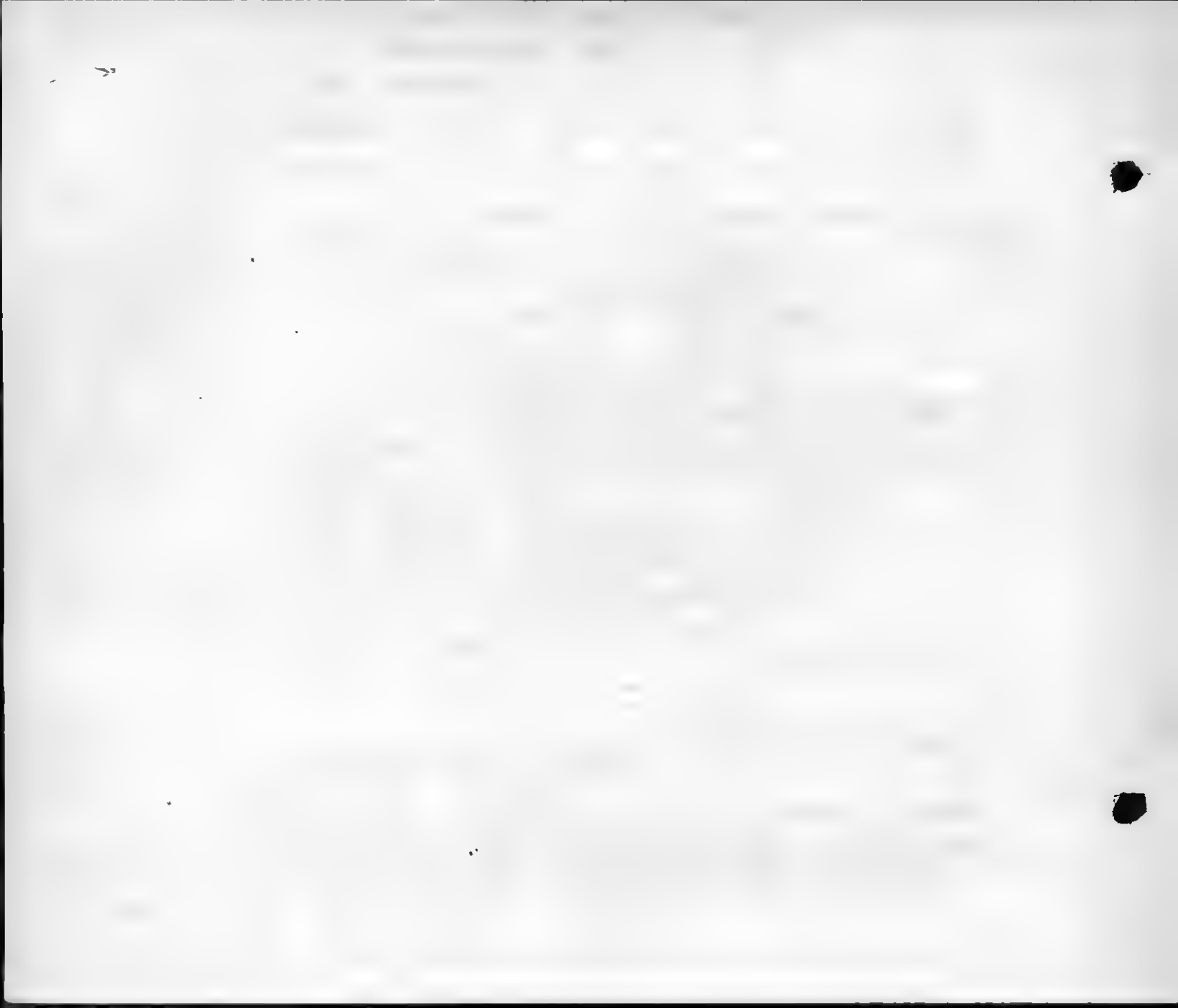
11860

CERTIFICATE OF DEATH

11845

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Claborne</u> | |
| | | f. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>William J. Ruhl</u> | | 4. DATE OF DEATH <u>October 18 1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 13 1906</u> |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William J. Ruhl Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma L. Faulkner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mrs. Eleanor D. Ruhl</u> | | Address <u>Same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> | |
| 526X DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) <u>Pneumonia - left lung</u> | |
| | | DUE TO | |
| | | (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic arteriosclerosis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1 Oct 1959</u> to <u>19 Oct 1959</u> , that I last saw the deceased alive on <u>18 Oct 1959</u> , and that death occurred at <u>3:50 A</u> M, from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. | | ADDRESS (Street, city or town, state) <u>Chesapeake Bay Land</u> DATE SIGNED <u>19 Oct 59</u> | |
| PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>22 Oct. '59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u> | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Smyth</u> | | 24a. REC'D BY REGISTRAR <u>Glen Burnie, Md</u> | 24b. REGISTRAR'S SIGNATURE <u>Chas. E. Kraus</u> |



CERTIFICATE OF DEATH

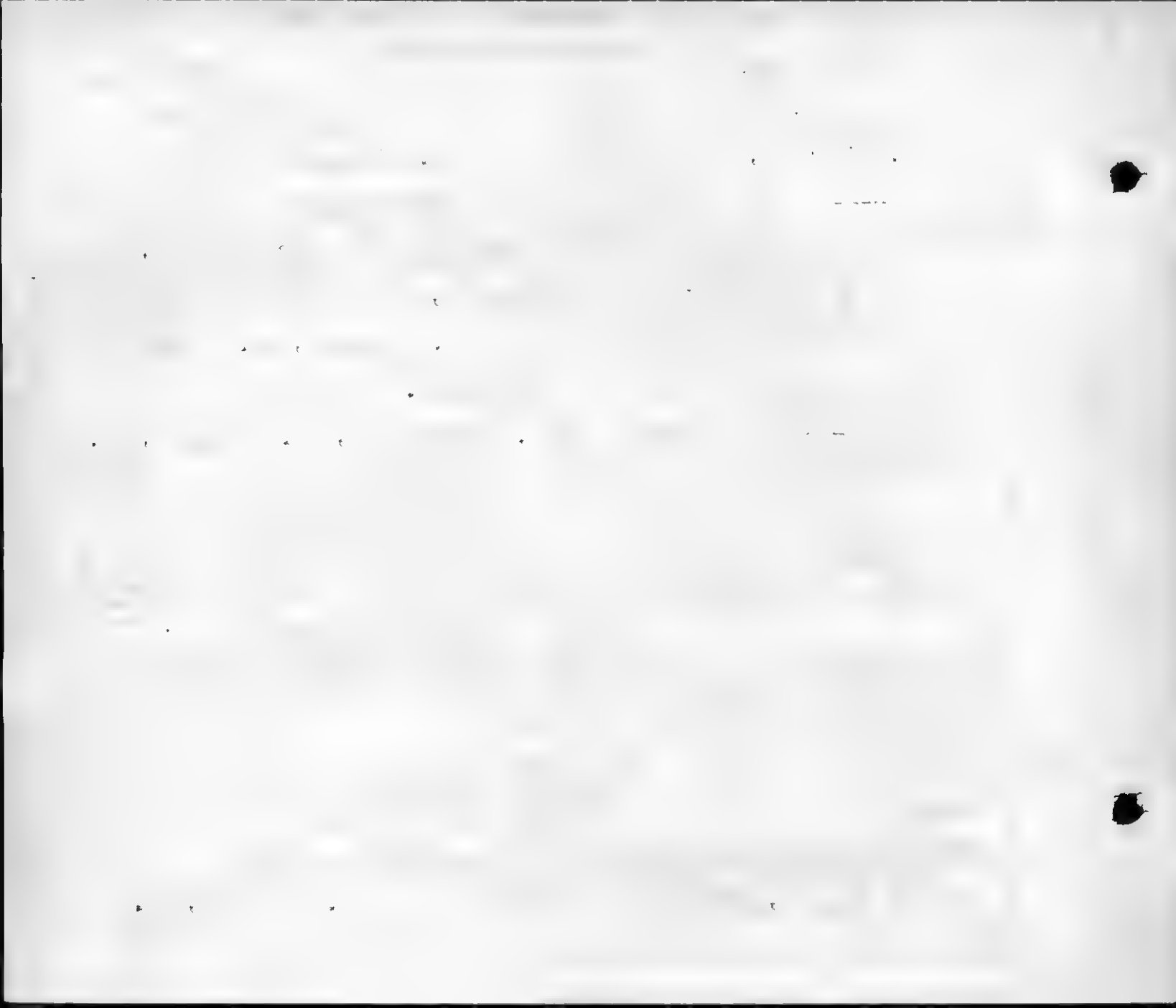
11846

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH o COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels, | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chew Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DANIEL Middle ERNEST Last SHOCKLEY | | 4. DATE OF DEATH Month October Day 10, Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 23, 1877 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR: Months 82 Days 82 Hours 82 Min. 82 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | |
| 11. BIRTHPLACE (State or foreign country) St. Michaels, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME David Shockley | | 14. MOTHER'S MAIDEN NAME Mary A. Jones | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Mrs. Susie Caulk, St. Michaels, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion DUE TO (c) Coronary Occlusion | | INTERVAL BETWEEN ONSET AND DEATH 10/10/59 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10 Oct , 19 59 , to 10 Oct , 19 59 , that I last saw the deceased alive on 10 Oct , 19 59 , and that death occurred at 10:00 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. Trullish M.D. | | ADDRESS (Street, city or town, state) 132487, St. Michaels, Md. | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 10/10/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct 13, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) St. Michaels, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison, St. Michaels, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 19 59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11847

11861

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock, md</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Williamsburg Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charlene Essee Spry</u> | | | | 4. DATE OF DEATH <u>October 17 1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov 11 1957</u> | | 9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Winfield Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Betty Spry</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Betty Spry, Hurlock, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corbolic dehydration</u> <u>292.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Suble cell anemia</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Birth</u> to <u>19</u> , that I last saw the deceased alive on <u>2:15</u> and that death occurred at <u>2:15</u> A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | | | DATE SIGNED <u>2-19-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | ADDRESS <u>Easton, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 20, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Petersburg Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hampton & Son</u> | | | | ADDRESS <u>Federalburg Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 20 59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>C. E. S. Jones</u> | | | |



11848

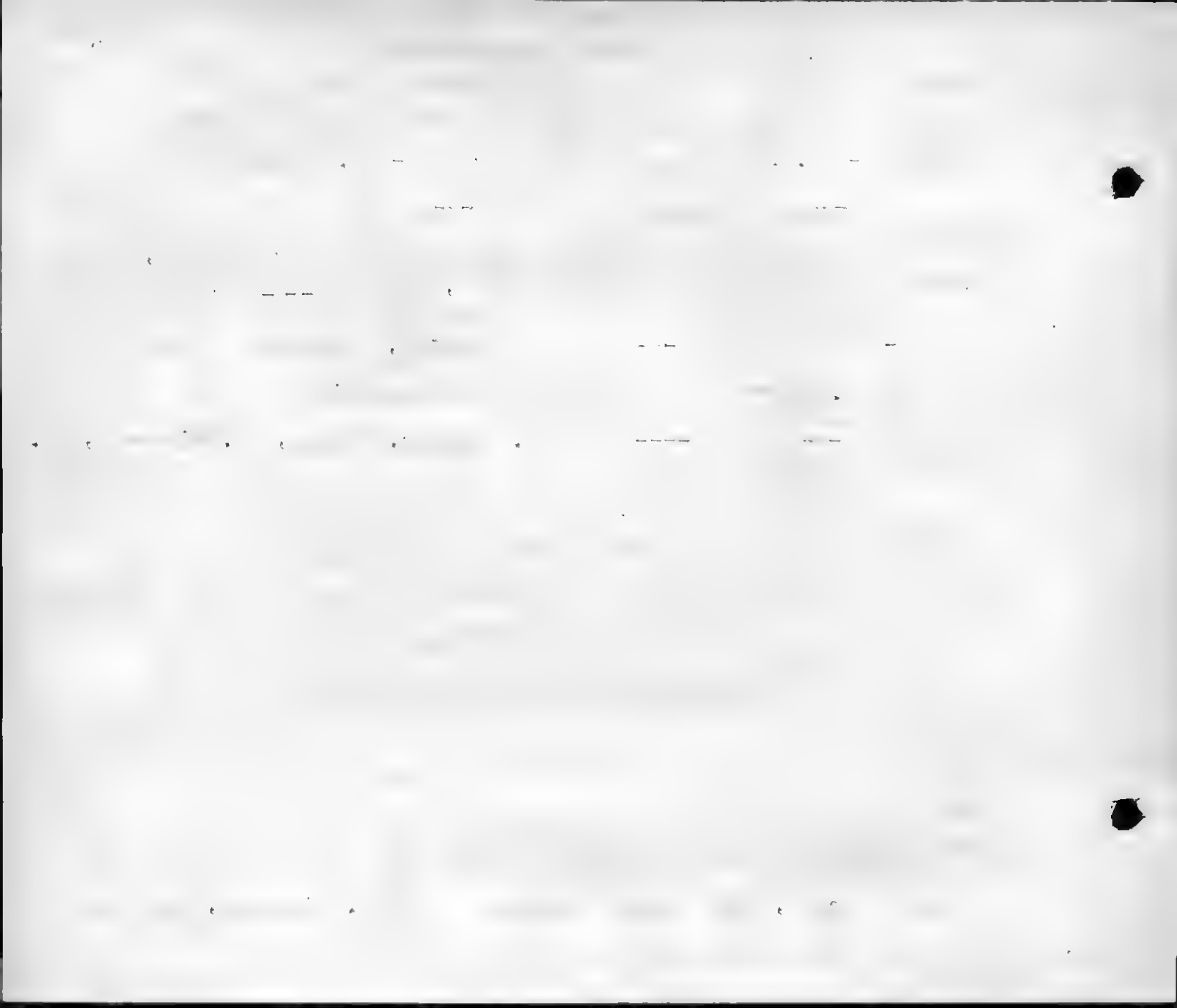
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland | | b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - St. Michaels | | c. LENGTH OF STAY IN 1b 4 mos | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - St. Michaels | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --- | | d. STREET ADDRESS --- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FRANCES CLARA SPURRY | | First Middle Last | | 4. DATE OF DEATH Month Day Year October 7, 1959 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH June 4, 1959 | | 9. AGE (In years last birthday) 22 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. 4 3 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Easton, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James B. Spurry | | 14. MOTHER'S MAIDEN NAME Kitty Chaplin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO --- | | 17. INFORMANT Address Mrs. James B. Spurry, St. Michaels, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive heart disease 45 NOT TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) 1. Aortic stenosis DUE TO 2. Aplasia ventricular septum. (c) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | |
| 20f. (City or town) --- | | 20g. (County) --- | | 20h. (State) --- | |
| 21. I certify that I attended the deceased from 27 Oct 1959 , to 19 , that I last saw the deceased alive on 27 Oct 1959 , and that death occurred at --- M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 219 S. Washington St 70159 | | DATE SIGNED 219 S. Washington St 70159 | |
| ACTUAL SIGNATURE E. C. H. Schmidt | | M.D. --- | | DATE SIGNED --- | |
| PHYSICIAN'S NAME (Type) E. C. H. Schmidt | | ADDRESS --- | | DATE SIGNED --- | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 8, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery | |
| 22d. LOCATION (City, town, or County) St. Michaels, Maryland | | 22e. (State) --- | | 22f. (Country) --- | |
| 23. FUNERAL DIRECTOR'S SIGNATURE --- | | ADDRESS --- | | 24a. REC'D BY REGISTRAR DATE OCT 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE --- | | 24c. (City or town) --- | | 24d. (County) --- | |
| 24e. (State) --- | | 24f. (Country) --- | | 24g. (City or town) --- | |
| 24h. (County) --- | | 24i. (State) --- | | 24j. (Country) --- | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

11849

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KIO VISTA | | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CORA Middle ADELE Last STACK | | 4. DATE OF DEATH Month Oct. Day 21 Year 1959 | |
| 5. SEX FEM. | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 14 - 1879 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RED CROSS EXECUTIVE | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOSEPH STACK | | 14. MOTHER'S MAIDEN NAME LYDA WILLIAMS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. T. HAROLD DAVIS - CENTREVILLE | |
| 17. INFORMANT T. HAROLD DAVIS - CENTREVILLE | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Arteriosclerotic Cardiovascular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis | | INTERVAL BETWEEN ONSET AND DEATH 17 yrs 3 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 1957 to 21 October 1959 , that I last saw the deceased alive on 21 October 1959 , and that death occurred at 10:48 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. Kneale Wroth | | DATE SIGNED Oct 22 1959 | |
| PHYSICIAN'S NAME (Type) WROTH | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| BURIAL | OCT. 24 | CHESTERFIELD | CENTREVILLE MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane Church Hill, Ind. | | 24a. REC'D BY REGISTRAR OCT 28 1959 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kane |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11862

CERTIFICATE OF DEATH

Reg. Dist. No. 11850

| | | | |
|--|-------------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL</u> | | d. STREET ADDRESS <u>105 S. WASHINGTON ST.</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>ANNE F STEAD</u> | | 4. DATE OF DEATH Month Day Year <u>OCTOBER 19 1959</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEBRUARY 17 1900</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>EDMUND GOLDBOROUGH</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY COYLE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>-</u> | | Address <u>-</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.2</u> DUE TO <u>Respiratory depression & edema</u> | | | |
| (b) <u>Toxemia</u> | | | |
| (c) <u>Renovative synd</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | DATE SIGNED <u>2195 Washington St. 200459</u> | |
| PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u> | | ADDRESS <u>Easton, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct 21, 59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton Md</u> |
| 23 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>OCT 21 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11863

CERTIFICATE OF DEATH

11851

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Easton Memorial Hosp.</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Girl Stevens</u> | | 4. DATE OF DEATH <u>10/2/59</u> Day Month Year | |
| 5 SEX <u>Fe</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Oct 2 1959</u> |
| 9. AGE (In years last birthday) <u>1</u> yrs | | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. <u>1</u> <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTH PLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>James Everett Stevens</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Mae Crosby</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>Anna Mae Stevens, mother - Trappe, Md.</u> | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO <u>1 lb + 10 oz</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 2</u> , 1959, to <u>Oct 2</u> , 1959, that I last saw the deceased alive on <u>Oct 2</u> , 1959, and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Barbara Williams MD</u> | | ADDRESS (Street, city or town, state) <u>205 Earle Ave Easton Md</u> DATE SIGNED <u>10/7/59</u> | |
| PHYSICIAN'S NAME (Type) <u>Barbara Williams</u> | | M.D. <u>205 Earle Ave, Easton, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u> | | 22b. DATE THEREOF <u>10/6/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <u>OCT 8 '59</u> | | <u>G. L. E. Evans</u> | |



CERTIFICATE OF DEATH

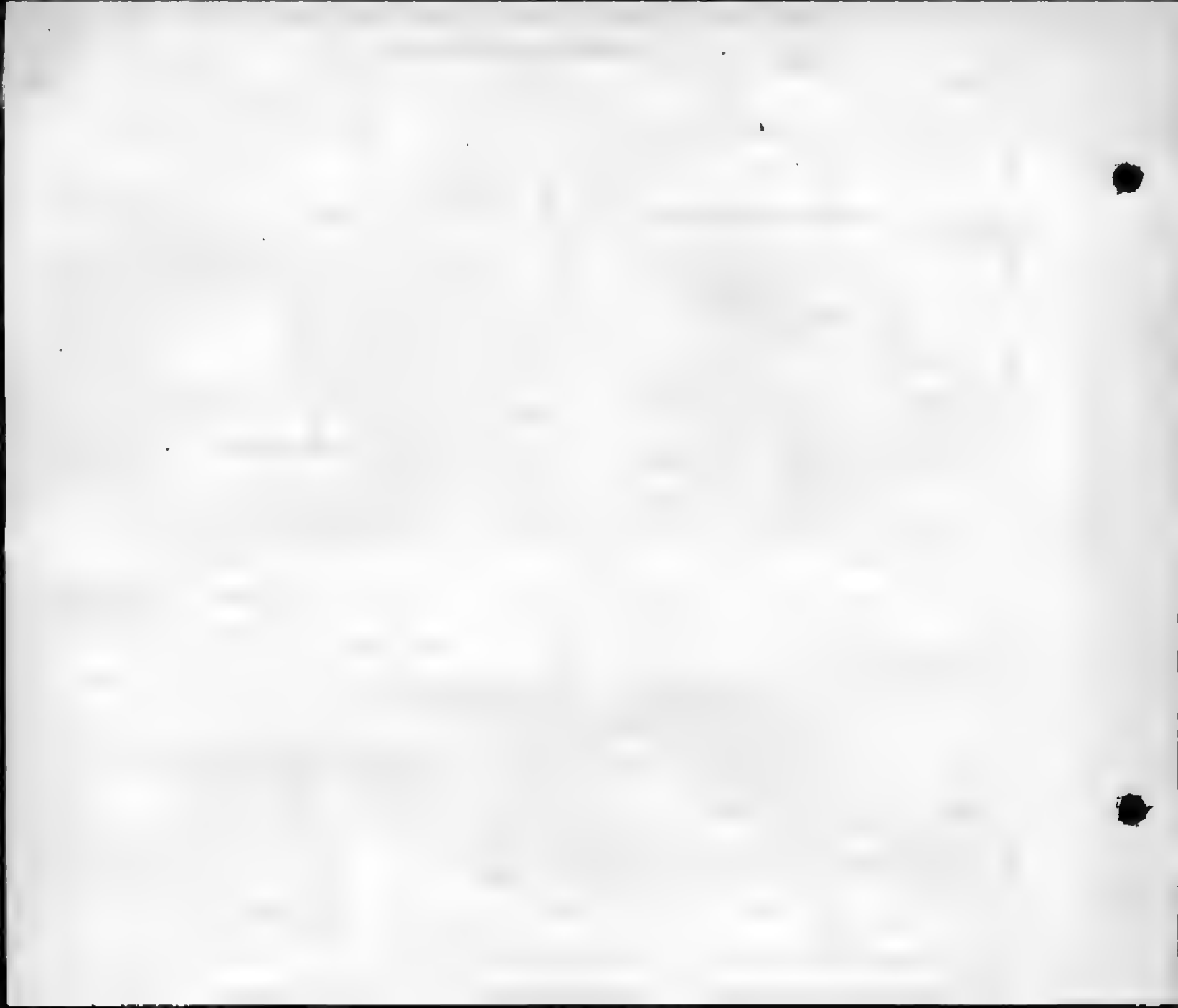
Reg. Dist. No. 11852

11864

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | c. LENGTH OF STAY IN 1b 3 1/2 hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON MEMORIAL | | e. STREET ADDRESS PO. BOX 11 | |
| 3. NAME OF DECEASED (Type or print) GEORGE C TAGG | | 4. DATE OF DEATH OCTOBER 26 1959 | |
| 5. SEX M. | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/20/1887 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM S. TAGG | | 14. MOTHER'S MAIDEN NAME MARY L. BAUBLITZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I | | 16. SOCIAL SECURITY NO. Mrs. Chas. E. Hurley Box 11 Crasonville Md | |
| 17. INFORMANT Mrs. Chas. E. Hurley | | Address Box 11 Crasonville Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral fracture DUE TO Cerebral fracture (c) Cerebral fracture | | INTERVAL BETWEEN ONSET AND DEATH (-) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding, chronic, decubital ulcer | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1959 to 26 Oct 1959 , that I last saw the deceased alive on 26 Oct 1959 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thurston Harrison | | DATE SIGNED 26/10/59 | |
| PHYSICIAN'S NAME (Type) THURSTON HARRISON | | M.D. Carlton S. Hines | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10-29-59 | 22c. NAME OF CEMETERY OR CREMATORY Parkwood | 22d. LOCATION (City, town, or county) (State) Balto. Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE William S. Tagg | | 24a. REC'D BY REGISTRAR OCT 27 '59 | |
| ADDRESS Easton, Md | | 24b. REGISTRAR'S SIGNATURE Carlton S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11865

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|-----------------------------------|--|--|----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp. | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) Mary Tilghman | | 4. DATE OF DEATH Oct 7 1959 | | | |
| 5. SEX Fe | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 1869 | | |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Charles Lowery | | 14. MOTHER'S MAIDEN NAME Louise Wallace | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. Myrtle Murrell - (great grand daughter) Wash. D.C. | | | |
| 17. INFORMANT Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte imbalance 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Persistent diarrhea (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 7:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 219 E. Washington St. Easton, Md. DATE SIGNED Oct 13 1959 | | | | | |
| ACTUAL SIGNATURE E. C. H. Schmidt M.D. | | PHYSICIAN'S NAME (Type) Easton 16, Maryland | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) Burial | 22b. DATE THEREOF 10/10/59 | 22c. NAME OF CEMETERY OR CREMATORY Royal Oak Cemetery | 22d. LOCATION (City, town, or county) (State) Easton, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. R. Schell ADDRESS Easton, Md. | | 24a. REC'D BY REGISTRAR DATE Oct 13 1959 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frazee | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Form with multiple lines for handwritten information, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle JOHNSON Last TRELEASE | | 4. DATE OF DEATH Month October Day 2 Year 19 59 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 28, 1887 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) consultant engineer | |
| 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William Trelease | | 14. MOTHER'S MAIDEN NAME Julia Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Frank J. Trelease | | Address Oxford, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hyper tension | | INTERVAL BETWEEN ONSET AND DEATH sudden 10 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July , 19 50 , to 2001 , 19 59 , that I last saw the deceased alive on 22 Sept , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED 6 Oct 59 | | | |
| ACTUAL SIGNATURE Thurston Harrison M.D. | | | |
| PHYSICIAN'S NAME (Type) Dr. Thurston Harrison | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 5, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oxford | | 22d. LOCATION (City, town, or county) (State) Oxford, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son | | 24a. REC'D BY REGISTRAR DATE OCT 8 '59 | |
| ADDRESS Easton, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

